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Medical Service Corps Celebrates 55 Years of Service

By Aveline V. Allen, Bureau of Medicine and Surgery

Financial management, patient administration, entomology, audiology, psychology, microbiology ... many specialties, one corps. The Medical Service Corps' 3,306 active duty and Reserve personnel celebrate 55 years of dedicated service on Aug. 4.

"Our highly diversified team of clinicians, scientists and administrators who make up the 32 different specialties in our Medical Service Corps continue to play a vital role in carrying out the mission of the Navy Medical Department," said RADM Philip VanLandingham, MSC, director of the Medical Service Corps.

"Maintaining the health and wellness of our active duty personnel, retirees and their families, is the primary reason we exist, and we do it very well."

According to VanLandingham, it's the people who make the corps so special.

"The single most enjoyable element of being the director of the Medical Service Corps is the pleasure of knowing that I am serving with some of the most highly diversified, and professional group of individuals in Navy Medicine," said VanLandingham.

"The MSC vision of 'many specialties, single mission, one corps' embraces our role in readiness and wellness and focuses our strength on achieving the mission of the Navy and Marine Corps team," said VanLandingham. "We perform countless duties on multiple platforms."

From scientists and clinicians to administrators, the many specialties that comprise the MSC all aim for three important goals: creating a cohesive team in support of Navy missions, capitalizing on the expertise, experience and diversity of their specialties and enhancing career development.

"We've gained great credibility in our ability to manage the community, and as a result, better meet the requirements to respond to our most important job - Force Health Protection," said VanLandingham.

Not only have these officers been meeting the goals of Force Health Protection, but also have demonstrated their unwavering commitment to duty as shown in their vital response in the aftermath of Sept. 11.

"The last year has been filled with exciting moments and numerous examples of MSC performing beyond expectations, and reaching new levels of

professional excellence," said VanLandingham. "When I observe the enthusiasm, the eagerness, and the potential that each of our officers has, I am convinced that this corps' future is in very capable hands."

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Navy Medicine Providers Learn the Art of Survival

By Doug Sayers and JO2(SW) Terrina Weatherspoon, Naval Medical Center San Diego

CAMP PENDLETON, Calif. - It's only a 40 minute drive from downtown San Diego, but for the Navy doctors, nurses, corpsmen, and specialists who are taking part in the Combat Skills Survival Course, it might as well be on the moon.

Located in an isolated corner of the Marine Corps' Camp Pendleton, the course is sponsored by the 1St Marine Expeditionary Force and Marine's 1st Force Service Support Group to teach skills to Navy Medicine personnel who will be forward deployed with them.

"The Combat Survivor Skills Course was initiated to increase survivability by giving (doctors, nurses and hospital corpsmen) a small sampling of the required skills in a combat zone," said LCDR Richard Haworth, MC, officer in charge of the course.

The four-day course takes doctors, nurses, corpsmen, and other specialists through a variety of situations they might expect to experience in the field. Training begins long before students reach Camp Pendleton - an online interface provides instruction in land navigation, weapons familiarization, medevac, mines, and Law of Armed Conflict. The online instruction allows more time for hands on instruction at the course.

As the war on terrorism continues, U.S. forces will likely be deployed at locations worldwide, often under remote and stark conditions - a far cry from clean, modern and accessible Navy medical facilities.

"Marines usually fight close to shore where they can be easily resupplied," said LCDR Steve Temerlin, MC, who recently returned from Afghanistan and was now a guest lecturer at the course. "That was not the case at Camp Rhino. They were 400 miles into Afghanistan and away from the ships. They had no local support, such as water, food, and fuel. Corpsmen did their best with what they had, but it was a totally unique situation. And that is why we are training."

To provide the most current information on what skills are needed by Navy Medicine personnel destined for deployment, returnees from such places as Afghanistan's Camp Rhino brief students and instructors on what took place and suggest course improvements.

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Arthur, Martin Assigned

WASHINGTON, DC - Chief of Naval Operations ADM Vern Clark announced today the following flag officer assignments:

RADM Donald C. Arthur Jr., MC, is being assigned as Commander, National Naval Medical Center Bethesda, Md. and Chief of the Medical Corps. Arthur is currently assigned as deputy director for Naval Medicine, N093B, Office of the Chief of Naval Operations, deputy chief, Bureau of Medicine and Surgery and Chief of the Medical Corps.

RADM Kathleen L. Martin, NC, is being assigned as deputy director for Naval Medicine, N093B, Office of the Chief of Naval Operations and deputy chief, Bureau of Medicine and Surgery.

Martin is currently assigned as Commander, National Naval Medical Center, Bethesda, Md.

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From The Desk Of Dr. Bill Winkenwerder

FALLS CHURCH, Va. - I've been on the job nine months now as the Assistant Secretary of Defense for Health Affairs. I've had the great opportunity to travel to a number of regions, visit our military medical treatment facilities here and in Europe, meet many of the outstanding people who make up the Military Health System, and learn about the many innovative practices that you have implemented.

I am sure that every new member of the MHS - whether a senior appointee such as myself, a new physician or a young enlisted member--is awed by the breadth of our operations, the depth and quality of our medical team, and the skill with which we execute our mission. Secretary Rumsfeld expects that we will operate a truly world-class health care system. From what I have seen, I think we have one - but we need to do more. The roadmap that the Secretary has given us is transformation, that is, eliminating inefficient practices and substituting modern business practices that are mission focused, leading to dramatic leaps in our overall performance.

My intention, through this regular column, is to shine a spotlight on those transformational initiatives that I have observed that are showing early success, and are easily exportable - with the understanding that one size does not fit all. I also intend to maintain the attention of my senior leadership on these innovative local initiatives.

I recently returned from an important visit to the European theater. There were a number of innovative ideas put forward to me during that visit - and some of those innovations may be covered in a future column. But I want to focus on one - the region-wide initiative known as Open Access.

Open access - an idea first introduced just a couple of years ago by Kaiser in California - is simple in concept but can be difficult in execution. The concept was developed by a Kaiser medical team - physicians, nurses and assistants - who had become understandably frustrated with the never-ending backlog of patients needing appointments. In addition to the frustration and the inefficiency from high levels of canceled or missed appointments, these primary care providers also understood that, most importantly, delay in care threatened quality. Here is how the Kaiser team first responded to the problem: "We developed new appointment types; we centralized the phones; we decentralized the phones; we tweaked the reception area; we conducted "service recovery" programs; and we got out our whips and beat the physicians and staff a little harder. Of course, none of that worked."

Sound familiar?

But then the team tried "open access." Open access dictates that you "Do today's work today." Studies of appointment systems have shown that with an established and stable panel of enrollees, demand is actually very predictable. Significant numbers of appointment slots are reserved for that day's work, and when patients call for an appointment, they are offered an appointment that day. On some days, that may mean a longer work day than on others, on other days, the work day may be shorter. But it prevents backlogs - and the bane of many beneficiaries, the dreaded "our appointment books are full, please call again next week."

As I said earlier, execution is not as simple as the concept. Significant planning and commitment is required from leadership and all levels of staff. But I am thrilled with the regional effort in Europe to attempt it. Not every MTF is fully exploiting this radical approach. Nonetheless, what I admired about this effort was that it reflected a bottom-up innovation in the MHS. Young leaders and risk-takers saw an opportunity to make a revolutionary change in access to care and implemented a program that is focused on the patient. At the Bamberg Army Health Clinic, they were averaging four day waits for primary care appointments.

Following the implementation of Open Access, they are now tracking waiting times for an appointment in hours, not days! Just as importantly, in the past a patient would see his or her primary care provider only 30 percent of the time they came for a visit. After Open Access, patients saw their own provider 70 percent of the time.

I know that Open Access has been tested in other MTFs in other regions as well - and I applaud everyone who has challenged the status quo and introduced this idea in their local facility.

Improving access brings with it a cascade of positive effects - a better patient-provider relationship, higher quality, lower cost, improved satisfaction.

We must be committed to fostering a culture that rewards innovation. My priority is to establish communications that ensure good ideas are shared; that headquarters staffs are attentive to field input and are responsive; that when these innovations are proven to be effective, we communicate effectively and resource the system-wide efforts.

I don't think that you need a national directive to be creative. No one can beat the military's ability to apply a good idea and get results. Open access can work. It is truly a transformational approach to a chronic problem. I urge those who are trying it to share that knowledge regularly with others, at regional conferences and at the national TRICARE conference, and I look forward to hearing more about it other places that I visit.

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TRICARE Prime Remote Pre-enrollment Begins Aug. 1

FALLS CHURCH, Va. - Active duty family members, who reside with their sponsors in remote locations, may pre-enroll in the TRICARE Prime Remote for Active Duty Family Members (TPRADFM) program Aug. 1 to 20, 2002. To pre-enroll, family members must submit a TRICARE Prime enrollment application to their regional managed care support contractor by Aug. 20.

"Pre-enrollment in the TPRADFM program is voluntary, but highly recommended, for active duty family members who live in remote locations and are not currently enrolled in TRICARE Prime," said Coast Guard Lt. Cmdr. Robert Styron, TRICARE Prime Remote (TPR) project manager, TRICARE Management Activity.

"The interim 'waived charges benefit', a program initiated by the Department of Defense to eliminate cost shares, co-payments and deductibles for active duty family members who accompany their sponsors to remote locations, ends Aug. 31, 2002," Lt. Cmdr. Styron said. Starting Sept. 1, active duty family members who are not enrolled in the TPRADFM will again be responsible for paying TRICARE Standard deductibles and cost shares, just as they did before the interim benefit was provided.

Family members who choose to pre-enroll, like others enrolled in TRICARE Prime, will have no cost shares or deductibles. Additionally, they will receive other TRICARE Prime benefits, including enhanced access and preventive care services and reimbursement of travel expenses for medically necessary care.

To pre-enroll in the TPRADFM program, active duty sponsors and family members must be identified as eligible in the Defense Enrollment Eligibility Reporting System (DEERS). They also must live and work more than 50 miles or approximately a one-hour drive time from the nearest military treatment facility.

In TPR locations where network providers serve as primary care managers, active duty family members already enrolled in TRICARE Prime do not need to enroll in the TPRADFM program.

In TPR locations where network providers are not available, active duty family members may pre-enroll in the TPRADFM program by completing a TRICARE

Prime enrollment application and submitting it to their TRICARE regional managed care support contractor by Aug. 20. Starting Sept. 1, these family members will be able to use the services of authorized TRICARE providers and pay neither cost shares nor deductibles. Family members who choose not to pre-enroll, may use the TRICARE Standard benefit and pay the usual cost shares and deductibles.

Active duty sponsors and family members may verify their eligibility for the TPRADFM program on the TRICARE Web site at www.tricare.osd.mil/remote. They may also verify their eligibility in DEERS by visiting or contacting the nearest military identification card issuing facility or contacting the Defense Manpower Data Center Support Office toll free at 1-800-538-9552. For up-to-date information on the TPRADFM program, sponsors and family members may contact or visit their local Beneficiary Counseling and Assistance Coordinator, TRICARE service center, or TRICARE managed care support contractor. A list of local and regional toll free telephone numbers is available on the TRICARE Web site at www.tricare.osd.mil/remote/benes/adf.html. They may also contact the Worldwide TRICARE Information Center toll free at 1-877-DOD-CARE (1-877-363-2273).

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TRICARE For Life Eligibility Deadline Extended

WASHINGTON, DC - The Department of Defense (DoD) announced today that the deadline for beneficiaries to update their eligibility in the Defense Enrollment Eligibility Reporting System (DEERS) and remain eligible for TRICARE For Life is extended until Sept. 1, 2002.

After Sept. 1, 2002, claims for beneficiaries who are not shown as eligible in DEERS will be denied and will no longer be sent electronically from Medicare to TRICARE for payment. These beneficiaries will be responsible for paying for services that Medicare does not cover.

Claims received for beneficiaries with expired eligibility will continue to be denied until their eligibility information is updated. By law, DoD must recoup (take back) payments made for ineligible persons.

Since the initial Aug. 1 deadline for updating expired eligibility was set, DoD has received health care claims for over 40,000 TRICARE For Life beneficiaries with expired eligibility, of which almost 19,000 have updated their eligibility. Approximately 4,000 lost their TRICARE eligibility due to certain events such as divorce from a military retiree, remarriage of a widow, or death. Nearly 17,000 beneficiaries, however, have not responded to mailings from DoD urging them to update their eligibility in DEERS so they may use TRICARE For Life.

In March 2002, DoD launched a campaign to reach this "hard-to-find" population and inform them of their new TRICARE For Life benefits and what they needed to do to ensure their eligibility was up to date. The Defense Manpower Data Center (DMDC), who oversees DEERS, mailed individual letters to beneficiaries and explained how to update their eligibility information and expired uniformed services identification (ID) cards.

"We urge beneficiaries to contact DMDC and update their eligibility in DEERS so they may continue to take advantage of this incredible benefit. We want to ensure that they have every opportunity to update their eligibility and use TRICARE For Life," explained Dr. William Winkenwerder, the assistant secretary of defense for health affairs, on the deadline extension. DoD will take advantage of the additional time and send more individual letters to beneficiaries who have not updated their eligibility information in DEERS.

TRICARE For Life beneficiaries who need to update or re-verify eligibility, or beneficiaries who have received an Explanation of Benefits

(EOB) stating that they need to update their eligibility, should contact the nearest ID card facility for assistance. The Web site developed to help beneficiaries locate the three nearest ID card facilities is www.dmdc.osd.mil/rsl/

Beneficiaries also may call the DoD Benefits Reverification Telephone Center at 1-800-361-2620.

For more information about TRICARE For Life, interested persons may visit the TRICARE Web site at www.tricare.osd.mil/tfl or call the Worldwide TRICARE Information Center toll-free at 1-877-DOD-LIFE (1-877-363-5433).

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MN023107. HealthWatch: How You Can Be Cool
By CDR David Horn, MC, U.S. Naval Hospital Yokosuka, Japan

YOKOSUKA, Japan - It's hot.

In most areas of the U. S. - and for that matter most of the Northern hemisphere - the temperature is up, the humidity is up, and it's getting you down.

For many, it's more than a matter of discomfort. High heat and humidity can be dangerous. Excess heat retention and dehydration can lead to a variety of heat-related injuries.

The most common heat-related incident, and the one that gets the least attention, is sunburn. Sunburn not only damages your skin leading to skin cancer but also promotes dehydration. The key to fun in the sun is frequent application of sunscreen and protection from the direct rays of the sun, especially during the peak hours of the day from 10 a.m. to 4 p.m.

Heat rash is skin irritation caused by reduced ability of sweat to evaporate. The rash usually appears as pimples on the neck, groin area or under the arms. Loose, absorbent clothing makes it easier for sweat to evaporate.

Heat cramps are painful spasms that occur mostly in the arms and legs caused by an excessive loss of salt. The key to treatment: provide cool water and a shady location for the person to cool down.

Heat exhaustion is caused by fluid loss from profuse sweating without enough fluid replacement. The individual will often get a headache; feel weak, tired and nauseous; and appear pale with cool moist skin.

Treat heat exhaustion by getting victims to a cool, shady location. Give them plenty of water to drink and have them lay down for a while. Personnel should obtain medical treatment to ensure victims are properly recovering and rehydrating.

Heat stoke is the most serious heat condition and is a true medical emergency. It is caused when the body's temperature regulating system fails and the body stops sweating. This causes an increase in internal body temperature because the body can no longer dissipate heat.

People become dizzy, confused, with headache and nausea. The skin is red and hot to the touch. Heat stroke rapidly leads to delirium, loss of consciousness, coma, and death.

Heat stroke must be treated quickly by soaking the victim's clothes with cool water and getting them to a cool shaded area. Fanning will help to increase the cooling. Medical treatment must be obtained promptly or damage to internal organs, the brain, or death will result.

Heat affects the elderly the most, and every year people die from it. But you don't have to be elderly - last year the Minnesota Vikings lost player Kory Stringer from heat stroke. The Navy and Marine Corps lose several people a year to the heat. Last year one of those casualties occurred right here on my home base of Yokosuka. Heat Stress is not something to be taken lightly.

So how can we enjoy the summer without becoming a heat stress statistic?

The most important thing you can do is to stay hydrated. The best way to do that is to drink water regardless of whether you feel thirsty or not. Drink at least eight glasses of water a day under normal conditions and even more when the heat is up. The loss of fluid causes the body core temperature to rise, leading to heat exhaustion and heat stroke.

Your urine is the best indicator to tell if you have enough fluid intake. It should be pale yellow. Dark urine indicates that you are losing water and need to drink more.

A word of advice: health care professionals are strongly advising against the use of "fat burner" dietary supplements, especially when taken before strenuous exercise. People may be at greater risk if taking supplements and exercising in the heat.

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